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6 September 2008

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See page 17





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Comment from the Editor

The diverse nature of community pharmacy is a key reason why it is such an exciting and innovative sector. From enormous corporations that combine retail, wholesale and manufacturing divisions, to small family businesses, the general public has an envious choice of providers.

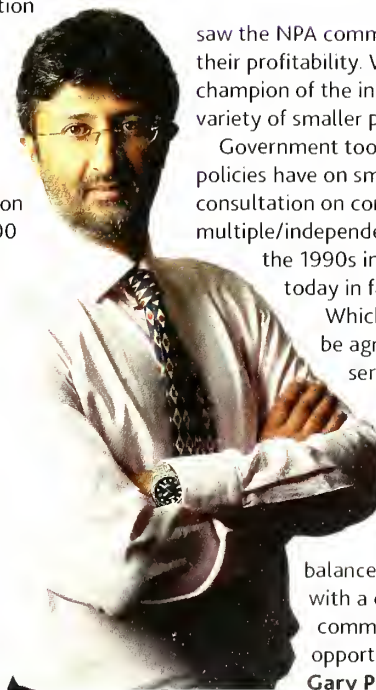
This intensely competitive environment has seen providers offer a range of additional services to gain that elusive commercial advantage. Whether it is collection and delivery services, diagnostic screening, extended hours, mail order services, drive-through pharmacies, or MDS services, competition on the high street has seen pharmacy push the innovation envelope.

So research to be released at next week's BPC predicting independents face a "bleak" future is alarming (p6).

Looking to a future when PCTs increase commissioning activities, Aston University researchers asked over 1,000 community pharmacists whether they believed pharmacy could compete with other providers for funding for services.

Unsurprisingly, pharmacists believe the larger pharmacy players will find it easier to attract service funding, the survey found. Consequently independents believe they will be left to fight over an ever-diminishing pot of cash – further hastening the decline of the independent sector, says the study.

But perhaps the future is not as bleak as it appears. Last week



saw the NPA commit to helping members increase their profitability. While Numark is emerging as a champion of the independent sector along with a variety of smaller professional development groups.

Government too now recognises the impact its policies have on small businesses. Last week's consultation on control of entry highlighted how the multiple/independent split has moved from 35/65 in the 1990s in favour of independents to 61/39 today in favour of multiples.

Whichever camp you are in, there must be agreement that patient choice is best served by a diversity of providers. A future dominated by a handful of large players is no better than 12,000 individual providers.

With the pharmacy white paper set to shape our landscape further, the sector's paymasters must balance the desire to increase competition with a commitment to ensure every community pharmacy has an equal opportunity to compete for new services.

Gary Paragpuri, Editor

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Retail demands can impact on professional judgement

Non-pharmacist managers need to understand professional demands, says expert

Jennifer Richardson

Pharmacists have been prevented from exercising their professional judgement and adhering to ethical guidelines in some retail settings, representatives and locums have warned.

Problems reported to C+D by two locums in the north of England include staff being removed from pharmacies without pharmacists' agreement, a pharmacist being pressurised to make a sale against his professional judgement, and a lack of necessary breaks.

These problems sometimes arose because non-pharmacist managers may not fully understand regulations governing the profession, a prominent pharmacy law and ethics expert and the employee pharmacists' union said. It is unclear if this is widespread or isolated incidents.

The CCA, which represents the largest retailers, said its members' non-pharmacist managers were trained in pharmacy regulations and ethics. Morrisons, Boots and Asda all corroborated this statement. Sainsbury's and Tesco

were unable to comment as C+D went to press.

Law and ethics expert Professor Joy Wingfield said: "There's little recognition within some large chains that pharmacy isn't the same as other retailing... it must be because they're increasingly using non-



Pushing it: pharmacists report pressure to make sales and lack of breaks in some retail outlets

Has the industry got a problem?

"The Society is unable to comment on the individual circumstances of any case. In order to foster better working relationships, staff should be aware of the roles and responsibilities of the pharmacist and other pharmacy staff. It is important that staff are aware of the important role of the pharmacist and their need to make the care of their patients their first concern."

Priya Sejjal, head of professional ethics, RPSGB

"It is normal practice for senior supermarket managers to be robustly trained about pharmacy so they understand their responsibilities, and how all staff can work together to serve customers."



"In a complex store environment misunderstandings can occasionally happen... [but] procedures are in place to protect the interests of the company's pharmacists in upholding their professional responsibilities."

Rob Darracott, CEO, CCA

"We have rigorous processes in place to ensure the total autonomy of the superintendent pharmacist and all pharmacists employed by Morrisons. On appointment, full training is given to pharmacy managers concerning the RPSGB's Code of Ethics and professional standards. We back this up with a training programme for our store general managers focusing on compliance with pharmacy regulation."

Bruce Pimlott, superintendent pharmacist, Morrisons

"Boots gives non-pharmacy store managers specific training so they are aware of all current ethical policies and have up to date information."

Boots spokesperson



pharmacists for managerial roles... these non-pharmacists don't understand the professional demands you work under as a pharmacist."

Pharmacists' Defence Association director John Murphy agreed: "The pharmacist is seen as an appendage to the retail operation... queues and trolleys full of groceries are much more important to the business than the pharmacy."

Asda superintendent pharmacist John Evans said he was not aware of any barriers to pharmacists' professional autonomy in its stores. Pharmacists had the right to refuse requests for pharmacy staff to work in other departments but were encouraged to release staff if they were not busy, Mr Evans said. Asda insisted its pharmacists took breaks.

And pharmacists must take charge of their own destiny, Mr Evans added. "They are professionals so they must stand up to anyone who [tries to] override them."

Give store managers compulsory regs training, say experts

Non-pharmacist managers of retail stores with a pharmacy should be required to train in pharmacy regulations by the RPSGB's ethical guidelines. This is the view of the employee pharmacists' union and a pharmacy law and ethics expert, as well as locums contacted by C+D.

The Royal Pharmaceutical Society "certainly could" do more

to increase non-pharmacist managers' understanding of the profession, the PDA and Professor Joy Wingfield agreed. The duo recommended adding requirements into the Code of Ethics for non-pharmacist managers to be trained in pharmacy matters.

Professor Wingfield, former ethics lead at the Society, called on the RPSGB to act in line with

Article 6 of the Pharmacists and Pharmacy Technicians Order 2007: "This [article] seems to me to positively allow the Society to issue guidance to non-pharmacist managers and the like who are managing pharmacists."

RPSGB head of professional ethics Priya Sejjal said it was important that staff were aware of pharmacists' important role and

their need to put patient care first. She declined to comment on whether this could or should be included in the Code of Ethics.

But PDA director John Murphy said: "The time is now as more and more pharmacies are being operated by commercial animals and non-pharmacist managers." And a north of England locum said this was "long overdue". **JR**

Society breaches code, says regulatory council

Failure to assess Council members mars positive review

Zoe Smeaton

The Royal Pharmaceutical

Society has breached minimum standards by failing to assess its Council members, NHS bosses have warned. The comments came as part of a broadly positive review of the RPSGB's regulatory performance by the overarching NHS regulator.

The Council for Regulatory Healthcare Excellence (CHRE) said the Society had no system to appraise RPSGB Council members, meaning it fell short of minimum requirements.

The RPSGB said there was little point in introducing a review mechanism due to the impending loss of its regulatory role.

However, overall the Society had performed well as a regulator in a period of transition, CHRE ruled.

NHS chiefs praised the Code of Ethics as "well laid-out, clear and concise".

Wendy Harris, the Society's

deputy registrar & director of regulation, said the Society's regulatory team should be congratulated on such a positive report.

Graham Phillips, a pharmacist and ex-RPSGB Council member, questioned the value of CHRE's analysis. He told C+D: "Who is judging CHRE's performance?"

Mr Phillips said the most important point was that the regulatory agenda had gone too

far at the Society, leaving pharmacists "intimidated, demoralised and frightened to practice pharmacy".

Mr Phillips added that he was in favour of appraisal of Council members, but agreed that spending money on an appraisal system was now not worthwhile.

CHRE also said that in future pharmacists should be forced to undertake continuing professional development.

PSNI limited by 'outmoded' rules

The CHRE report found that although the Pharmaceutical Society of Northern Ireland (PSNI) fulfilled most of its functions satisfactorily, it was limited in its ability to improve and innovate by "outmoded legislation". For example, PSNI could not enforce CPD standards or remove people from the register if necessary.

PSNI president Raymond

Anderson said the Society would be introducing key performance indicators, a revised code of ethics and a new website in the next few months.

He added that PSNI was grateful CHRE supported a new legal framework and that it looked forward to finalising the legislation to provide a fresh toolkit of regulatory powers.

Second fuel surcharge revealed

Pharmacists have been hit with another fuel surcharge as UniChem this week became the second wholesaler to pass on spiralling forecourt prices to customers.

Contractors will be charged £14 + VAT per month from September 8, UniChem said.

The fee will not apply to medicines supplied under direct to pharmacy or agency deals (Pfizer, AstraZeneca, GSK and Astellas transplant medicines), the wholesaler stressed.

The move comes after diesel prices reached a record-breaking £1.33 per litre this summer.

UniChem said it could no longer absorb rising fuel costs without compromising service levels.

PSNC said it was in discussions with the Department of Health on reimbursing contractors for fuel levies passed on by wholesalers.

Phoenix customers have faced a £9.75 per month surcharge since February.

Martin Sawyer, executive director at the BAPW, predicted other distributors would follow Phoenix and UniChem.

He said: "There's a lot of others in the pipeline. We've been warning the Department this would happen for a long time."

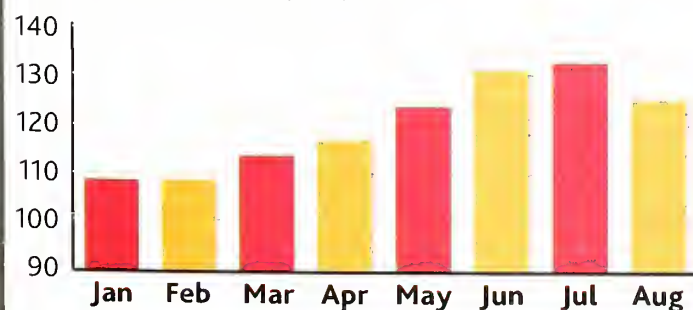
AAH, now the last of the big three UK wholesalers not to operate a fuel levy, said: "AAH has made every effort to absorb this cost, but clearly there are limits to the degree to which we can continue to do so."

UniChem said its fuel charges would not be reimbursed if contractors suffered service problems. Contractors with service issues should contact their local UniChem customer manager, the wholesaler said. **MG**

Paying the price:

Average diesel price per litre (pence) in 2008

Source: AA



Are fuel levies unfair on contractors?
mgnosney@cmpmedica.com

News in brief

Join the C+D team

C+D is looking for a pharmacist to join its editorial team as a full-time reporter based at its office in Tonbridge, Kent. If you're eager to learn and have a keen interest in pharmacy news and politics, email your CV and covering letter to C+D editor Gary Paragpuri at gparagpuri@cmpmedica.com

Global sum adjustment

Investment in pharmacy premises and businesses' goodwill values should be factored into global sum negotiations, Community Pharmacy Scotland has said.
www.chemistanddruggist.co.uk

Job Dunn

Steve Dunn, ex group managing director of AAH, has joined the board of Protomed as a non-executive director. Protomed designs products for the healthcare sector.

Technicians barred

Pharmacy technicians will not be able to join the new pharmacy professional body, TransCom has decided. Instead they will be offered affiliation through the Association of Pharmacy Technicians UK (APTUK).
www.chemistanddruggist.co.uk

Statin supply splits GPs

A proposal to allow pharmacists to supply statins without prescription has met with mixed reaction from GPs. Full story at www.chemistanddruggist.co.uk

Premises fee rise plan

The RPSGB has submitted a bid to the Department of Health for permission to increase premises fees to £183 for 2009. The Society requested the go-ahead for a rise to recover "exceptional costs" including pension fund contributions and a rise in its inspectorate's fuel costs. The move was discussed at a Council meeting on Thursday.

p.s. Find out how a Dragon's Den reject has made the big-time with Boots. And why the RPSGB's Sandra Melville goes all gooey over Jon Bon Jovi. Turn to PostScript, page 34

Obesity map highlights case for full-scale fat-fighting services

Contractors should lobby PCTs in high risk areas for weight management role, says industry

Jennifer Richardson

An obesity map of the UK could help contractor representatives negotiate local community pharmacy weight management services, national bodies have said.

But the nationwide report of obesity prevalence across the country, by primary care organisations, was criticised by the NPA for failing to mention the potential contribution of pharmacy in tackling the problem.

UniChem NHS services manager Richard Balcon said the map, produced by public-private healthcare information provider Dr Foster, could "help when submitting a business plan that would support a PCT in achieving their objectives [to reduce obesity]".

The NPA and PSNC agreed the map could be a "useful prompt" for discussions with local commissioners. But the NPA recommended the use of more detailed local data for service proposals. The association also

pointed out that obesity was more than just a local problem.

NPA head of professional services Tonia Morton said: "Obesity is a national problem and an increasing one. The NPA would therefore see a place for a national obesity service available from community pharmacy."

The map indicated that in nine areas that had ongoing or recently completed pharmacy weight management services (according to PSNC's services database), six had a 'low' or 'lowest' obesity prevalence. One of these was Coventry Teaching PCT, the site of UniChem's award-winning obesity service. Mr Balcon said: "Coventry's key objectives are to halt the progression of obesity in the area and the community pharmacy project has played an important part in supporting these."

Should obesity services get national funding?
jrichardson@cnpmedica.com

Areas with pharmacy obesity services

Fife

Hull

Heywood, Middleton & Rochdale

Coventry

City

Kensington

Wandsworth

Eastern & Coastal Kent

Southampton City

Obesity prevalence (QOF) by primary care organisation

■ Highest
■ High
■ Medium
■ Low
■ Lowest

Bleak future in store for independents, says research

Research to be presented at next week's British Pharmaceutical Conference has predicted a "bleak" future for independent pharmacy.

A survey of more than 1,000 pharmacists showed that 37 per cent of those working in independent pharmacies believed they would not be able to compete effectively for funding to develop services. This compared to just 18 per cent of those working in multiples.

The Birmingham researchers concluded: "Community pharmacists believe that the larger pharmacy chains and supermarkets will occupy an advantageous position in terms of attracting finance to develop services."

A second survey, which questioned 71 male pharmacists about their career prospects and satisfaction, found respondents "pessimistic" about independent

contractors' future. This could have "far-reaching" consequences, the researcher said, limiting patient choice and access to pharmacy services, and threatening some pharmacists' career ambitions and the profession's attractiveness.

"Policy makers should be aware that in the current political climate the future is bleak for the independent community pharmacy sector," the paper said.

Researchers added that patient access would be restricted by a decline in the number of independents. Pharmacists' career ambitions would also be thwarted by a reduction in the independent market. JR

Do independents have a future?
jrichardson@cnpmedica.com

Multiples alarmed by greater PCT disciplinary powers

Proposals to hand PCTs greater power to scrutinise the performance of individual pharmacies and pharmacists are a cause for concern, multiple contractor representatives have said.

A consultation on April's pharmacy white paper, launched last week, outlined plans to allow PCTs to end contracts, withdraw payments on inadequate quality of service grounds and scrutinise individual pharmacists' performance.

CCA and AIMp Ltd chief executive Rob Darracott said: "We... would express an initial concern over the ability of PCTs to assess standards, the potential for the development of a multiplicity of views over what is an appropriate standard or quality of service, and the double jeopardy that may arise from standards inspections or competency

assessments by both PCTs and the regulatory body."

NPA head of external relations Stephen Fishwick agreed: "Our support for a lot of the measures in the white paper is contingent on PCTs' capacity and capabilities."

However, Numark interim managing director John D'Arcy said: "As a principle, you'd have to say that if someone wasn't doing the job properly they shouldn't be allowed to continue." But further details were needed, he added.

The NPA criticised the absence of a timetable for proposed market entry changes outlined in the consultation. "Any testing and evaluation of changes to the 100-hour exemptions [should not be] prolonged because the market needs to stabilise so contractors can make the investment in services." JR

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Information about adverse event reporting can be found at www.yellowcard.gov.uk Adverse events should also be reported to Rosemont Pharmaceuticals Ltd on 0113 244 1400.

Dispensary TALK

Will drive-through pharmacies work in the UK?



"During normal operating hours I cannot see drive-through pharmacies working as you cannot beat the consultation environment offered in a typical pharmacy. However, I can see a small use for the service providing that it is offered out of hours for those who need products late at night for example."

Brian Deal, Ashwell Pharmacy, Herts



"I can see it working in cities where people are generally busier and may prefer not to wait for their prescriptions. However I cannot see it being so successful in more rural areas where many people enjoy building up a relationship with their pharmacist."

Jennifer Reid, Fair Oak Pharmacy, Streatham, London

WEB VERDICT:

Yes ☐ 41%
No ☐ 59%

Armchair view: The first McDonald's pharmacy may have to wait. While it might work for fast food chains, your gut instinct says drive-through prescriptions won't pull in the punters quite like burgers, chips and fries.
Next week's question: How many times have you been to the British Pharmaceutical Conference? Vote at www.chemistanddruggist.co.uk

UniChem sets sights on expanding virtual chain

Fee structure revealed as Alphega looks to lure independents feeling cat M crunch

Max Gosney

UniChem plans to charge independent pharmacies between £250 and £499 a month to join its European-wide virtual chain, Alphega Pharmacy.

The fee structure was revealed as UniChem outlined plans to expand UK membership to the group it launched in the UK last November.

Sixty six pharmacies had signed up to the virtual chain so far, UniChem said. However, membership was likely to top 100 in the next six months as independents felt the strain of hostile trading conditions, the wholesaler predicted.

Mike Smith, UniChem chairman, said: "I think 2008-09 will bring the severest price cuts since category M started... I think now more than ever contractors need to look at options such as Alphega Pharmacy to drive their business forward in this tough climate."

Alphega members will receive advice from personal business consultants, who will help them cash in on revenue from providing enhanced services, UniChem said.

The basic £250 a month membership package also included branding and merchandising support, staff training and toolkits for setting up screening services.

An advanced £499 per month package was also available and included an externally benchmarked business audit, the wholesaler added.



Euro star? The Alphega chain has 1,000 members across Europe, with 66 UK pharmacies signed up so far

Asked whether these fees would prove prohibitive for independents who have reported cash flow problems after last October's category M cuts, Mr Smith said: "Pharmacists have to realise that they have to develop new income streams otherwise their standard of living will fall."

Rival symbol group Numark charges a £100 monthly membership fee with PharmaPlus costing £18.75 per month.

The Alphega Pharmacy group has over 1,000 members across countries including France, Spain and Italy.

The group's 2008 convention will be held in London this November.

Would you join the Alphega group?
mgosney@cmpmedica.com

Would you join?

Yes: "When you're competing with the multiple sector you need to be able to differentiate yourself. Alphega helps you to do that and provides essential branding and training support. I'm a very enthusiastic member and convinced it works."

Andrew Lane (Alphega member), Dulverton Pharmacy, Dulverton, Somerset

No: "I think in the present economic climate of pharmacy there won't be too many takers. Some of the service support would be useful as sometimes as an independent you get left to your own devices. However, it seems like an awful lot of money."

Warren England, England Pharmacy, Wigan

Tories promise secure funding

The Conservatives have outlined plans to ring-fence funding for public health services, including pharmacy-led weight management pilots.

The pledge came as Andrew Lansley, shadow health secretary, outlined Tory plans to tackle public health issues last week.

Mr Lansley described a "responsibility deal" between businesses and government

on public health.

In a Tory government, he said, there would be a focus on public health through local area agreements. These would incorporate direct local business involvement in campaigns to promote exercise and healthy lifestyles.

Mr Lansley also reported plans for a secretary of state for public health and separate

public health budgets.

He said having separate public health funds would ensure the monies went to support long-term action, and would not be siphoned off for other needs.

Gian Celino, director of Webstar Health, a pharmacy consultancy firm, said public health was one of pharmacy's strengths, and added: "Any guaranteed funding for it would be good." **ZS**



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December 2007. Accessed 26/12/07. Available from: www.nice.org.uk/CG57/2. Cork MJ et al. *Pharm J* 2003; 271(7277): 747-748. 3. Post-marketing surveillance Data on file. Reckitt Benckiser 2007. 4. Hobday MC & Largey P 1996, cited by Kirby and Kaye. Data on file.

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Date of preparation: August 2008



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It might sound too good to be true, but AAH says that by signing up to its private flu vaccination scheme, you could stand to make £3,700 every year (see panel, right). And just the other week the NPA also teased the profession with a potential income boost when it launched a chlamydia testing and treatment pharmacy service.

So what's the catch? The problem, according to some pharmacists, is that patients, particularly those in less affluent areas, just aren't going to pay for healthcare services when the NHS will provide them for free.

As John D'Arcy, interim managing director at Numark, says: "The reality is that if you're in the

AAH and the NPA have both launched private pharmacy-based clinical services in the past month. **Zoe Smeaton** asks whether the time is right for pharmacists to be going private?

The stats

AAH's flu vaccination service is available to Healthwatch customers at £449 + VAT (£527.57). This includes a pack of 50 vaccinations as well as the training and marketing support.

Additional vaccinations are £6.87 including VAT each. Pharmacists can charge as much as they like to administer the vaccinations, but as a guide, the RRP is set at £14.99.

Taking into account the initial charge for the service, five vaccinations per week over a 12-week period would yield a profit in excess of £300. But AAH expects pharmacists will be able to administer many more than this, and 40 per week would bring in a profit of more than £3,700.

Approximately 90 pharmacies have signed up to the service so far.

The NPA chlamydia testing and treatment service costs pharmacists £21 for the service pack. Patients will pay £25 for the test kit and a further £20 for treatment if required. Pharmacy revenues will depend on the cost of the products from wholesalers.

business of healthcare you have to have links with the NHS. NHS services are free at the point of delivery so while there is a market for private services there's always going to be competition."

Yet despite the fact that many private services are unlikely to attract large volumes of cash immediately after their launch, some pharmacists are still flocking to provide them. And C+D found that for attendees at one of the training days for the AAH flu vaccination scheme, money was not the main motivator.

Job satisfaction was enough reason for some. Lucy Dean, a pharmacist from Day Lewis, said she wanted to develop her professional role in order to help patients more. "Anything I can do to help patients is good," she explained.

Private services also offered a chance to gear up for a shift in income away from dispensing. As Sanjeev Patel, of Weston Pharmacy in London, said: "We have to move

Private services – what patients and GPs think

Michael Summers, vice-chairman of the Patients' Association

"We have nothing against [these services], people should have a choice. If pharmacists feel able to [offer these additional services] then so be it... it's what patients want, and if they can afford it too then it's a good idea. Sometimes it's very difficult to get an appointment with a GP... so there's a useful part to be played by pharmacy."

Peter Holden, GP and member of the British Medical Association's GP's Committee

"A lot of GPs are getting very fed up with other people cherry picking the easiest things to do. If you want to play at being a GP then go and do the 12 years' training. The administration of vaccinations is part of our income so why should we give that away to someone else?"

"adapt to the public's changing health needs, setting pharmacists as dedicated health professionals".

This could in turn lead to financial benefits, if it means PCTs are persuaded to commission more services from pharmacy.

Ajit Malhi, head of marketing services at AAH, agrees providing professional services could "support and provide evidence to PCTs and other organisations that pharmacy is right to provide these kinds of services".

If this isn't enough to convince

you though, there could be good news on the profit side of things too. AAH believes the convenience offered by pharmacy vaccination services could convince patients to open their chequebooks. And Mr Malhi said by eventually offering a suite of private services, not just one, pharmacists could "go some way to driving up revenues".

Further, as Mr D'Arcy concludes, things could be looking up, as with soaring NHS costs there is likely to come a time eventually when healthcare may have to be rationed

or charged for: "There is room for private services, and people may be prepared to pay them already, but there's no doubt more will come."

So it might sound too good to be true now, but pioneering private services early could leave pharmacists well placed to cope if purchase profits are going to be hit further in the future.

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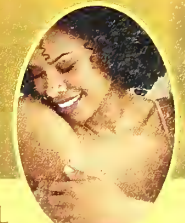
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away from the traditional ways of doing things with the available global sum going down."

Raj Nutan, head of business development at the NPA, agrees that moves to offer more services are appropriate as prescription volumes become less reliable sources of income.

For those looking further ahead, the vaccination service promised additional gains. Steven Foster, of Pierremont Pharmacy, Broadstairs, Kent, said he hoped this scheme would be the start of many for pharmacists, with the potential for them to be involved in travel vaccinations and others.

Mr Foster added that he planned to promote the service among local GPs, as vaccinating some patients could contribute towards general practice targets.

Whether this link to other professions could successfully be forged remains to be seen, but Rashmi Parmar, professional development services manager at AAH, believes the flu vaccination scheme could help pharmacists become part of more integrated primary care teams.

Image is also a factor. Mr Nutan says offering an effective private service could demonstrate the ability of community pharmacy to

The melatonin melee

A licensed melatonin product has finally become available, but brings with it as many problems as it solves.

Melatonin has been prescribed for a number of years, in a variety of formats and strengths, for whatever indications patients could find on the internet, and obtained easily enough on a 'named patient' basis from your friendly specials supplier. Now the MHRA has licensed Circadin 2mg m/r tablets for "short term primary insomnia characterised by poor quality sleep in patients aged 55 years and older" and probably wishes it hadn't bothered.

The latest missive I received from the MHRA is yet another jobsworth message for me to pass to GPs, this time about melatonin prescriptions. Now that a licensed product is available this must be used in preference to any other melatonin product, "whenever possible".

I'm aware of melatonin having been prescribed for a variety of ills, including jet lag and insomnia in children. Bizarrely enough, I'd never previously seen it prescribed for its now licensed indication. This newly licensed medicine could largely be prescribed 'off-label'.

Imagine trying to explain this to your GP: "Morning Doctor, I just need to warn you that you should now prescribe melatonin as 2mg

m/r tablets because these are licensed and the 3mg capsules you prescribed for six-year-old Danny aren't. I should also warn you that the 2mg m/r tablets aren't licensed for use in children. What do you want to do?"

"Ah, yes, go ahead thank you. One sugar please."

"So, will you write a new script for Danny for 2mg m/r tablets?"



"Plenty of Calpol and some antibiotics should do the trick."

"Thanks Doctor, I'll try and sort it out with your receptionist..."

So as usual, I advise the receptionist what to prescribe and at what dose, and cross my fingers that if anything untoward happened the GP would assume all responsibility. I wonder if this could qualify as supplementary prescribing?

If a GP is insistent on any other variety of melatonin apart from Circadin, they now have to write an explanatory letter to the importer. At least the MHRA's template letter should avoid me having to write to them on the GP's behalf.

This strange situation highlights the benefits of the standard, but much maligned, system for licensing drugs. Normally, Big Pharma Co invests a sum of money equivalent to the GDP of a small African nation in bringing a new drug to market. Then, it applies for a licence that covers the indications likely to be most popular and doctors prescribe new wonder drug as recommended. Pharmacists attach label to packet and, Bob's your uncle, happy patient, easy life and a few quid profit for Big Pharma Co and pharmacist. The alternative might save the NHS money in the short-term, but benefits no one in the long run.

Irish eye

Terry Maguire

Where now for NI's minor ailments scheme?

Buoyed up by considerable public support, contractors have in turn given their support to the Pharmaceutical Contractors Committee (PCC) in what is an overwhelming endorsement of PCC's stance on the Northern Ireland minor ailments scheme (NI-MAS).

We have reached an important junction, a place where the PCC has indeed a stronger mandate – perhaps the strongest mandate it has ever had. This is a good thing and for PCC a privileged place to be.

The trick for PCC now is to reward this support and the loyalty of contractors by negotiating a new pharmacy contract that will properly recognise the commitment of pharmacy contractors and the investments we have made in ensuring that a world class pharmacy service exists in Northern Ireland. A properly funded NI-MAS will, of course, be a key component of this contract. The public do indeed value their pharmacy service and why shouldn't they?

When Belfast's new underpass was filling up with rain – with more water than Beijing's Water Cube – many contractors were mopping dilute sewage out of their premises and even then out-of-hours-pharmaceutical services were still being provided in Belfast and across Northern Ireland. I know one family who were very grateful for the supply of medicines that soothed the dying hours of their patriarch.

Sadly, it's only when we don't provide our services that we begin to get noticed and local press coverage of our dispute

with the Department of Health, Social Services and Public Safety (DHSSPS) over NI-MAS has been strong and largely in favour of pharmacy. Yet most contractors are uncomfortable with the tactics of the militant unions and prefer to go quietly about their business. So I wonder for how long we will hold ranks.

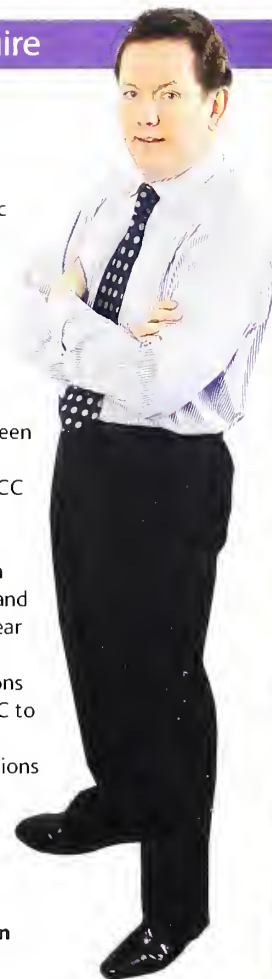
Should things continue without substantial negotiations happening I rather fear that PCC's position could weaken. DHSSPS has played the game too. It has been forthright in informing contractors that rather than negotiating on NI-MAS and failing to reach agreement, PCC did not engage in any negotiations on the service.

In August, the minister – keen to see progress – was adamant in a letter to PCC that what was on offer was, in his view, fair. However, he was keen to engage with PCC and promised that his negotiation team would be happy to hear from them at their convenience.

Business must be done and the hard work of negotiations must be started in earnest and so now it's over to the PCC to deliver. A stand-off will only serve to create its own problems. I can't help but think of the disastrous negotiations over flu vaccines a few years back where a brittle stance only served to remove us from the service all together.

In a harsh world the PCC has some careful calculations to make and it needs to ensure that it has done its homework properly.

Terry Maguire is a community pharmacist in Northern Ireland



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Control of entry: making choices

The government believes giving PCTs the power to link pharmacy contracts with local needs will mean control of entry simply falls away. But what impact will such a PCT-led utopia have on the location of pharmacy services, asks **Noel Wardle**

Since 1987, the provision of NHS pharmaceutical services has been limited to those who are on a PCT's pharmaceutical list. Getting onto the list involves an applicant jumping through the deliberately restrictive hoop known as 'control of entry'.

He or she must show the PCT that it is necessary or desirable to grant his application in order to secure, in the neighbourhood, the adequate provision of pharmaceutical services (usually referred to as the 'necessary or desirable test').

In 2002, the government commissioned the Office of Fair Trading (OFT) to look into control of entry. The OFT produced a 75-page report in January 2003 and concluded: "The control of entry regulations should be lifted. They inhibit price competition. They stifle efficiency, improvement and innovation. They limit the availability of pharmacy services. And they impose substantial regulatory burdens." The government decided against deregulation, choosing instead to "move cautiously" in the direction recommended by the OFT.

As part of its cautious move, the government introduced, under the



necessary or desirable test, a requirement for PCTs to have particular regard to whether patients in a neighbourhood have a reasonable choice of pharmaceutical services or service provider. However PCTs, and on appeal, the Family Health Services Appeal Unit (FHSU), have wrestled with the new regulations, not least because the term "reasonable choice" is not defined in the regulations. There has been

no consistency of approach and, on the whole, it has not seemed that the introduction of "reasonable choice" has made much difference to the number of applications granted under the necessary or desirable test.

One of the main contentious issues has always been, in a neighbourhood with no pharmacy, whether it can be said that patients have a reasonable choice of pharmaceutical services or service

providers and, if not, would the absence of reasonable choice always make it at least desirable to grant an application?

Some judicial guidance has now been given on the meaning of "reasonable choice" in the case of *R on the application of Assura Pharmacy Ltd v NHSU (FHSU)* [2008].

The case involved three applications by Assura Pharmacy Ltd for premises in Freckleton, Todmorden and Tunbridge Wells. In Freckleton, there was already one pharmacy in the town. Assura applied to open an additional pharmacy, but the PCT refused this. Assura appealed, in part arguing patients in Freckleton did not have a reasonable choice of pharmaceutical services or service providers. An FHSU-appointed panel carried out a site visit and held an oral hearing before recommending the application be refused because, irrespective of whether there was reasonable choice, the provision of pharmaceutical services was "totally adequate". Assura applied to the High Court for judicial review of that decision.

After hearing arguments from Assura, the FHSU and interested parties, Judge Hickinbottom decided that, in relation to the issue of choice, the regulations did not require the PCT to give a special weight to whether or not patients have a reasonable choice, adding: "None of the factors is determinative, or given pre-eminent or enhanced weight. The weight given to these factors or any of them is a matter for the decision maker."

He added that choice requires at least one alternative, so that there

Control of entry: the proposal for a new two-part approval process

The latest DH proposal for reforming control of entry in England is to replace the current market entry test with one based on local need as identified by PCTs' local pharmaceutical needs assessments (PNAs).

PCTs will be required to consider applications objectively against their PNAs; fairly and without bias compared with existing providers, and to set out transparently the basis and reasons on which

they have reached their decision.

In addition, to help PCTs make decisions on contracts, applications will be considered against a range of criteria, such as level of access, choice and diversity of providers, innovation in service delivery, the services available to specific populations or to meet specific health conditions, and the overall longer term impact of approving new applications.

Choice – key points for control of entry

- PCTs must have particular regard to whether there is a reasonable choice of pharmaceutical services or service providers.
- PCTs cannot ignore the question of choice.
- If there is only one pharmacy in a neighbourhood, there is no choice of pharmaceutical services.
- If there is only one pharmacy provider in a neighbourhood (even if that provider has more than one pharmacy), there is no choice of pharmaceutical service provider.
- It is up to the PCT to decide how much weight to give to reasonable choice (or lack of it).
- Even where there is no reasonable choice, PCTs can refuse applications, for example where the provision of pharmaceutical services is wholly adequate in all other respects.

services and service providers, to allowing patients to make choices about how and where they receive health services – at a hospital, in a doctor's surgery or in a pharmacy.

In last week's consultation on changes to control of entry, the Department of Health sets out its vision to link contract applications to PCTs' pharmaceutical needs assessments, which ministers hope will lead to a golden age when PCTs will be able to identify exactly what pharmaceutical needs exist in precisely which location. PCTs

could then commission the identified needs from "any willing provider".

When that time comes, Galbraith envisages that "control of entry will fall away". The question is, will this PCT-led utopia improve choice or will it simply mean that PCTs dictate which services should be provided in each area and, therefore, what choice patients are allowed to have?

Noel Wardle is a healthcare team member at Charles Russell LLP
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cannot be choice when there is only one service provider. The judge said: "However, it must be remembered that reasonable choice is only one factor that the decision maker has to take into account when considering the 'necessary or desirable test': and that the weight given to that factor relative to other factors is a matter for him. Choice – its presence, its absence or its extent/reasonableness – is not (or is rather not necessarily) the determining factor. Even where there is limited or even no choice, it is still open to a decision maker to find that, taking all the relevant factors into account, the provision of pharmaceutical services is adequate."

So where does this take us? It seems it is still up to the decision maker to decide what weight, if any, to give to the question of choice, although the PCT must at least put its mind to the question of choice when determining an application. Where the provision of pharmaceutical services in a neighbourhood is wholly adequate, but there is no choice, it will be rare for an application to be granted solely to secure "reasonable choice". However, in borderline situations the absence of reasonable choice will make it more likely that an application will be granted.

Up until now, there has been only patchy evidence that PCTs have sought "to promote consumer choice and harness the benefits of increased competition" as the Department of Health said it would if it rejected the OFT deregulation proposal and instead weakened control of entry.

But control of entry is once again under the spotlight following the Galbraith Review and pharmacy white paper. Both mention choice, although the emphasis seems to have shifted from whether patients have a choice of pharmaceutical

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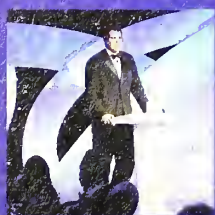



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C+D Clinical

Erectile dysfunction: 10 years on

A review of treatments since the launch of Viagra

Key points

- ED refers to a persistent or recurrent inability to attain or maintain an adequate erection.¹
- ED is common: 17.8 per cent of UK men contacted in a telephone survey reported erectile difficulties.³
- ED is associated with other concurrent conditions including hypertension, hyperlipidaemia, diabetes mellitus and depression.⁶
- Weight loss and increased physical activity can improve ED. The World Health Organization recommends oral therapies as the first-line treatment. Other treatments include surgery, injections and mechanical devices.⁴
- Sildenafil, vardenafil and tadalafil show broadly similar efficacy and toxicity. However, pharmacokinetic differences may allow clinicians to tailor treatment to the patient.⁴

Mark Greener

Ten years ago, the launch of a little blue pill impacted massively on the public consciousness. Viagra (sildenafil) rapidly became one of the few pharmaceutical brands familiar to the 'man in the street'. More importantly, the launch encouraged countless discussions of erectile dysfunction (ED) – formerly one of the diseases that dare not speak its name – on television, in magazines and newspapers, and on the internet. So where does ED management stand today?

A common problem

ED – "the persistent or recurrent inability to

Reflect

Which men are more likely to suffer from erectile dysfunction? How might non-drug methods help? For whom might tadalafil be more suitable?

Plan

This article discusses erectile dysfunction, who is likely to suffer from it and the treatment options available.



This article can help in the following CPD competencies: **G1a, G1c, C1b, C1c, C2a**. See <http://tinyurl.com/68ox7b>



The College of Pharmacy Practice



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Given the range of treatments available, pharmacists should encourage anyone with sexual dysfunction to consult their doctor

attain an adequate erection or to maintain one until completion of sexual activity"¹ – and other sexual problems are common. In one study, 40 per cent of women and 22 per cent of men attending general practitioners in London met the ICD-10 diagnostic criteria for at least one sexual dysfunction. Of the men, 8.8 per cent experienced ED.² A telephone survey of UK men found that 17.8 per cent experienced erectile difficulties, three quarters of whom experienced either periodic or frequent ED.³

Despite the growing awareness and acceptance of ED, much of this morbidity remains hidden. According to the telephone survey, only 39.5 per cent and 26 per cent of men suffering from ED or another sexual problem had talked to their partner or a medical doctor respectively. Furthermore, 12.5 per cent looked for information anonymously (eg in books or on the internet), while 11.4 per cent took drugs, used devices or talked to a pharmacist. However, almost half (48 per cent) took no action and a similar proportion did not consider sexual dysfunction to be a medical problem or believed that the doctor would be unable to help.³ Indeed, many men wait around two years before seeking treatment for their ED.⁴

Given the range of treatments now available, pharmacists should encourage anyone with sexual dysfunction to consult their doctor. And, of course, some pharmacies are piloting schemes to provide ED medicines off-prescription to suitable men.

The overlap with other diseases

Erections arise from the co-ordinated interplay of psychological, neurological, hormonal and vascular factors. As a result, affecting any one of these mutually reinforcing strands can cause ED.¹ For example, as the Porter in Macbeth notes, alcohol "provokes the desire, but it takes away the performance".

This interdependence also means that a man suffering from ED has a strong chance of suffering from a serious concurrent disease. For example, ED is associated with an increased risk (hazard ratio 1.58) of developing coronary heart disease (CHD) in men with type 2 diabetes.⁵ Furthermore, 42.4 per cent of ED patients show hyperlipidaemia, while 41.6 per cent and 20.2 per cent have hypertension and diabetes respectively.⁶

To consider the relationship from the other side: half of men who suffer from diabetes experience ED at least once. Indeed, men aged 40 to 69 years with diabetes were 83 per cent more likely than controls to develop ED.⁷ Moreover, 11.1 per cent of ED patients suffer from depression, which is a psychological cause of ED and an independent risk factor for CHD.⁶ Some antidepressants can also cause sexual



Sexual problems are common among older men

dysfunction, a point to consider among men reporting erectile dysfunction. Therefore, clinicians should investigate whether ED patients have symptoms of other conditions, such as cardiovascular disease (CVD), depression and diabetes.

Treating ED

Pharmacists can advise men that losing weight, increasing their physical activity and cutting back on the booze may improve ED. In one study, such lifestyle changes improved sexual function in approximately 30 per cent of obese men with ED. Other treatments include oral drugs, surgery, intracavernosal injections, intraurethral treatments and mechanical devices. The World Health Organization recommends oral therapies as the first-line treatment of ED.⁴

Phosphodiesterase⁵ (PDE5) inhibitors form the mainstay of treatment for ED.⁴ As their name suggests, these drugs block one particular type (isozyme) of phosphodiesterase. When a healthy man is sexually stimulated, nitric oxide relaxes the smooth muscle of the corpora cavernosa. This relaxation allows blood to engorge the penis.¹ Nitric oxide binds to, and activates, an intracellular enzyme called guanylate cyclase that synthesises the second messenger cyclic guanosine monophosphate (cGMP). In turn, the increased levels of cGMP relax arterial and trabecular smooth muscles.⁸ (A second messenger is a link in the intracellular 'transduction' chain that converts the signal encoded in a drug or neurotransmitter into the appropriate biological response.)

PDE5 degrades cGMP. By inhibiting the breakdown of cGMP, PDE5 inhibitors

augment the effect of nitric oxide and hence facilitate erections.¹ As such, PDE5 inhibitors are not aphrodisiacs. They don't provoke the desire, but improve the performance. Many couples feel more desire as performance improves, however.

Sildenafil, vardenafil and tadalafil show broadly similar efficacy and toxicity. For example, the PDE5 inhibitors show similar onsets of action: generally between 30 and 60 minutes after taking the medication. However, the speed of the onset of action varies between patients: 35 per cent and 51 per cent of patients taking sildenafil achieve an erection sufficient for intercourse within 14 and 20 minutes respectively. This compared with 22 per cent and 30 per cent respectively in the placebo arm.⁴

In a Cochrane review of eight randomised trials that enrolled men with type 2 diabetes mellitus, PDE5 inhibitors increased the likelihood of answering "yes" to the question "did the treatment improve your erections?" almost four-fold (relative risk [RR] 3.8). On average, men taking PDE5 inhibitors made 26.7 per cent more successful attempts at intercourse than controls.⁷

Differences between PDE5 inhibitors

Differences in the pharmacokinetic profile of the PDE5 inhibitors may allow clinicians to tailor treatment to the patient. For example, food – especially a high fat diet – delays the absorption of sildenafil and vardenafil, but not tadalafil.

Compared with fasted volunteers, food decreases the maximal plasma concentration (C_{max}) of sildenafil by 29 per cent and time to the maximum concentration (T_{max}) by approximately one hour. A high-fat meal reduces vardenafil's C_{max} and T_{max} by 20 per cent and up to one hour respectively.⁴

The duration of action also differs. Sildenafil's and vardenafil's duration of action persists for between four and five hours. In contrast, tadalafil's half-life is 17.5 hours, compared with 3.7 hours for sildenafil and between 3.3 and 3.9 hours for vardenafil. As a result, tadalafil's duration of effect is up to 36 hours. Therefore, all other things being equal, tadalafil may be more appropriate for men who prefer a broad window of time during which they can have intercourse.⁴

Precautions

PDE5 inhibitors are well tolerated. The Cochrane review reported that headache was the most common adverse event. Other adverse events included: flushing, upper respiratory tract complaints, flu-like syndromes, dyspepsia, myalgia, abnormal vision, and back pain. Overall, the review found that men taking PDE5 inhibitors

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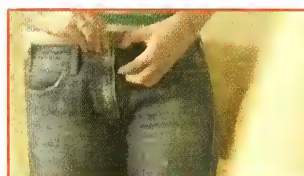
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<http://campaigns.tvlowcost.co.uk/>

CLIENT COMMENT

Jon Connolly, Director of Marketing, Ceuta Healthcare

"TVLowCost? Some 30yrs' experience showed throughout and we benefited from top-drawer strategic, creative, research, production and media buying support over the course of the project. TVLowCost and its Space City, Ipsos and Media team were approachable and open-minded throughout and positive movements in business and tracking measures made this whole initiative a remarkably successful and enjoyable venture. Our expectations were well exceeded."

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or mitchell@tvlowcost.com
www.tvlowcost.co.uk

Blog: <http://tvlowcostuk.wordpress.com>

were 4.8 times more likely to develop adverse reactions compared with controls.⁷

More recently, a warning about sudden decrease or loss of hearing has been added to the possible adverse reactions of vardenafil.

Given the overlap between ED and CVD, cardiovascular safety is a particular theoretical concern. Pfizer originally developed sildenafil as an anti-anginal. PDE5 inhibitors treat pulmonary hypertension and may even, in the future, find a role in essential hypertension. Against this background, retrospective and controlled clinical trials do not suggest that these drugs increase the risk of either myocardial infarctions or mortality.

Furthermore, PDE5 inhibitors do not seem to increase the short-term risk of myocardial infarctions following sexual intercourse.⁶

Nevertheless PDE5 inhibitors should be avoided in serious cardiac conditions such as recent stroke or myocardial infarction, hypotension and unstable angina, and used with care in renal or hepatic impairment.

They should not be taken at the same time as nitrates or drugs that inhibit or induce cytochrome P450 3A, such as ketoconazole, itraconazole, alpha blockers, HIV protease inhibitors and grapefruit juice.

When PDE5 inhibitors fail

When PDE5 inhibitors fail, patients and clinicians can choose surgery (eg penile implants), mechanical devices or other drugs. For instance, alprostadil (synthetic prostaglandin E1) administered as an intracavernosal injection or using a urethral applicator offers another safe, effective ED treatment. Alprostadil is mainly used second-line by patients in whom oral treatments are either contraindicated or ineffective.⁹

Psychotherapy may enhance the effectiveness of PDE5 inhibitors or even prove effective without pharmacological support. Sex group therapy (which can involve couples as well as men alone) includes training in social and communication skills, assignments to reduce sex-related anxiety, and information and education about male sexuality.

A Cochrane review of pooled data from two randomised trials found that such psychotherapy reduced the number of men with "persistence of erectile dysfunction" after treatment by 87 per cent (relative risk 0.13). Sex group therapy showed a 95 per cent response rate compared with none in the waiting list control group. Two trials compared group therapy plus sildenafil with Viagra alone. Those also receiving group therapy plus sildenafil were 54 per

cent less likely to report persistent ED (RR 0.46) and 71 per cent less likely to drop out (RR 0.29) than those taking Viagra alone.¹⁰

Pharmacological augmentation offers another possible approach in some patients with concurrent diseases. Pioglitazone increased the likelihood of responding to sildenafil in men in whom Viagra had previously failed. 58 per cent and 11 per cent of men in the pioglitazone and placebo arms respectively reported improved erections and sexual activity. Pioglitazone probably acts in ED, in part by increasing the production, release and bioavailability of nitric oxide.⁸

Conclusion

Viagra's launch 10 years ago marked a sea change in attitudes towards ED and the wider management of sexual dysfunction. However, despite the increased awareness among the general public and healthcare professionals, and a growing armamentarium, many men delay seeking treatment. The growing number of treatments allows clinicians to tailor treatment to each patient and allow the couple to get on with their lives inside and outside the bedroom.

References can be found online at www.chemistanddruggist.co.uk/update

Mark Greener, a former research pharmacologist, is a freelance writer on health-related issues.

Your Continuing Professional Development



Act

- Read the BNF section 7.4.5 Drugs for erectile dysfunction. Note the cautions and side effects and under what circumstances treatments may be prescribed on the NHS.
- Think about how you could counsel a new patient. How could you tactfully suggest that an overweight man who drank too heavily might benefit from a change in lifestyle?
- Read the information on the US National Kidney and Urologic Diseases Information Clearing House website <http://tinyurl.com/4av3o> for more details about erectile dysfunction and its treatment.
- Look at the websites for erectile dysfunction sufferers and their partners, 40 over 40 – www.40over40.com/index.html and Lovelifematters – www.lovelifematters.co.uk/index.html (sponsored by Lilly). Think about any advice you could give to a patient who enquires about treatment or perhaps even a woman asking on her partner's behalf. Print out or order the leaflets available if you think they may be useful.

Evaluate

- Are you familiar with the treatments for erectile dysfunction and their side effects? Do you know who is most likely to suffer from this condition? Could you give advice to a patient asking about treatment?

MUR ZONE

More than 100 MUR tips and guides at:
www.chemistanddruggist.co.uk/murzone

For a free weekly email alert on C+D's
Pharmacy Update series, register at:
www.chemistanddruggist.co.uk/register

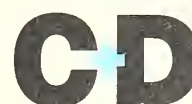


CPD Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the October 4 issue, which will cover this

month's three CPP-accredited modules. A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on 01732 377269.

Chemist+Druggist in association with
Genus Pharmaceuticals



GENUS PHARMACEUTICALS

A Practical Approach

Underpaid locum

Salma Hussain, formerly pre-registration trainee pharmacist at the Update Pharmacy, phones David Spencer, her former tutor, at his home one evening.

"I'm sorry to trouble you again, David. I always seem to be calling when I've got a problem," she says.

"Don't worry," replies David. "How can I help you this time?"

Salma continues: "You know that I'm back doing locums again while I think about a change in career direction? Well, last week I did a few days for an independent. We agreed on a fee of £25 per hour.

"The day after I finished I received a letter from the owner saying that business hadn't been too good lately and, as the pharmacy had been very quiet while I was there, I wouldn't have had to work hard so he was only paying me £20 an hour. He enclosed a cheque for £800 instead of the £1,000 I was expecting.

"I'm furious, but I don't know what I can do to get him to pay me the rest of the money he owes. Do you think the Royal Pharmaceutical



Society would help? After all, surely renegeing like that on a professional agreement is unethical?"

"I think I know how you could go about getting the money, but I'm not sure what the Society would do," says David.

Questions

1. How might Salma go about recovering the underpayment?
2. Would the Royal Pharmaceutical Society take any action?

which Salma would have to attend). There is also an organisation – the Pharmacists' Defence Association – that represents employe and locum pharmacists in employment disputes such as this. If Salma is or becomes a member, it would take up the case for her. If Salma and the pharmacy owner were both members of the National Pharmacy Association, the latter might be prepared to try to mediate between them.

2. The Royal Pharmaceutical Society would be unlikely to take any action in this case, which it would regard as a financial dispute to be settled between the parties involved. The Society recently decided that the disciplinary system would not deal with 'minor employment issues'.

1. The owner of the pharmacy is clearly in breach of contract, and he has confirmed this in his letter to Salma. She has a legal right to the underpaid amount. Her first action should be a letter to the owner requesting the money, stating she will take further action if payment is not received by a specified date. If this is unsuccessful, she could make a claim through the 'small claims track' of the county court. This is quick, simple and inexpensive, and claims can now be made online. Most claims are paid without being contested. Claims can also be made for recovery of the fee for making the claim and for any earnings lost in making it (eg if the claim was contested and there had to be a court hearing).

Answers

This article can help in the following CPD competencies: G2e, G2j, G2k, G2o, G7d. See <http://tinyurl.com/68ox7b>



C+D's
A Practical
Approach
is supported by



• Can you suggest a scenario for Practical Approach? Email your ideas to haveyoursay@cmpmedica.com

Clinical Alerts – Sign up for C+D's clinical newsletter at www.chemistanddruggist.co.uk/register

MHRA Alerts

Human papillomavirus (HPV) Routine immunisation programme for HPV across the UK for 12–13-year-old girls (school year 8) began on September 1. The vaccine Cervarix protects against infection with HPV types 16 and 18.

www.mhra.gov.uk

SPC Changes

Diclomax Retard (diclofenac sodium) Information on zidovudine. Galen, 028 3833 4974, customer.services@galen.co.uk

Apidra 100U/ml solution for injection in OptiClik cartridge, SoloStar pre-filled pen, solution for injection (insulin glulisine) Changes to indications and pharmacodynamic properties. Sanofi-Aventis, 01483 505515, uk-medicalinformation@sanofi-aventis.com

Natrilix (indapamide) Extensive changes including contraindications, special warnings and interactions. Servier Laboratories, 01753 662744.

Derbac M Liquid, Prioderm Lotion (malathion) Information on skin and hypersensitivity

reactions. SSL International Plc, 0161 638 2027, medical.information@ssl-international.com

Solu-Medrone 2g (methylprednisolone, sodium succinate) Changes to special warnings and undesirable effects. Pharmacia, 01304 616161.

Norzol 200mg/5ml Oral Suspension (metronidazole) Changes to warnings, interactions effects on ability to drive, and undesirable effects. Rosemont Pharmaceuticals, 0113 244 1400.

Lustral (sertraline) Change to

section on pregnancy and lactation. Pfizer, 01304 616161.

Tamiflu 75mg hard capsule, 12mg/ml powder for oral suspension (oseltamivir) Changes to indications and undesirable effects. Roche Products 0800 328 1629, medinfo.uk@roche.com

Trifluoperazine 5mg/5ml Oral Solution (trifluoperazine) Changes to warnings, undesirable effects and interactions. Rosemont Pharmaceuticals, 0800 919312.

<http://emc.medicines.org.uk>

Positive experience

86% of Imigran Recovery users would recommend it to family and friends.¹

¹TNS Imigran Recovery Pharmacy Spotlight, November 2007

Acute relief of migraine attacks. Further information is available from GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS. Legal category: P. Date of Preparation: April 2008.



sumatriptan

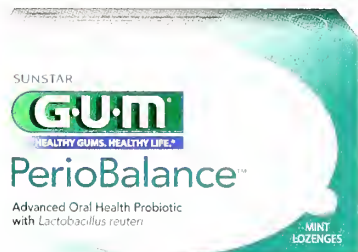
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¹ Çağlar E et al. Oral Disease 2005, 11: 131-137

IN DENTAL PRACTICES AND PHARMACIES

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www.sunstargum.co.uk

SUNSTAR



Family testing identifies hypercholesterolaemia

Nice has instructed health professionals to refer familial hypercholesterolaemia patients for confirmation of diagnosis and 'cascade' testing of relatives.

This group of patients is also to receive a high-intensity statin regime to achieve a recommended reduction in LDL-C concentration of 50 per cent of the baseline level.

The cascade process will involve both DNA tests and measurement of low-density cholesterol, and where possible should include first-, second- and third-degree relatives in an attempt to identify as many individuals with FH as possible.

Where a known mutation for hypercholesterolaemia is found, DNA testing will be used to identify at-risk relatives. But, where no known genetic cause is identified, patients will be categorised by low density cholesterol concentration into three groups.

Concentrations over 3.5mmol/l are said to indicate that familial hypercholesterolaemia is 'likely', while 3.1-3.4mmol/l makes the possibility regarded as 'uncertain'. Levels below 3.0mmol/l make hypercholesterolaemia 'unlikely'.

Nice also suggests children of parents with a known mutation for

hypercholesterolaemia should be DNA tested at 10 years old. Where no mutation is known, the child should be tested for low density cholesterol, and again after puberty.

Writing in the BMJ, cardiologist and preventative medicine expert Dr David Wald said the uncertain category was unhelpful as it would apply to large numbers of patients, including 5 per cent of children and 20 per cent of adults or more. Nice guidelines on familial hypercholesterolaemia:

<http://tinyurl.com/6yhrvc>
British Medical Journal 2008; 337: a1304 – www.bmj.com

Clinical News

Serotonin and SAD

Positron emission tomography brain scans have suggested that changes in levels of the brain's serotonin transport may be a cause of seasonal affective disorder, say researchers in the Archives of General Psychiatry. Arch Gen Psychiatry 2008; 65:1072-8.

<http://archpsyc.ama-assn.org>

Telmisartan results

Results from the TRANSCEND trial have shown treatment with telmisartan (Micardis) reduced a composite endpoint of CV death, MI, stroke and congestive heart failure by 13 per cent in patients unable to tolerate ACE inhibitors. A second trial published by the New England Journal of Medicine suggested it makes little difference to stroke recurrence when used early after stroke, however.

www.lancet.com

NEJM abstract:

<http://tinyurl.com/699prz>

Effective as clopidogrel

Aspirin with extended-release dipyridamole is as effective as clopidogrel in preventing recurrent stroke following a first episode, results in the New England Journal of Medicine suggest.

NEJM abstract:

<http://tinyurl.com/579ob6>

MTRAC goserelin verdict

Assessments from the Midland Therapeutics Review and Advisory Committee have recommended goserelin for prescription in prostate cancer in primary care. A revised assessment did not recommend leuporelin for lack of evidence it is clinically effective.

MTRAC assessments:

<http://tinyurl.com/63qo8r>

Study finds heart rate link

Coronary artery disease patients with left ventricular dysfunction and a heart rate over 70bpm are at high risk of myocardial infarction and other cardiovascular events, and benefit from treatment with ivabradine, results of the BEAUTIFUL trial have found.

The trial also revealed patients whose heart rate was over 70bpm

were 34 per cent more likely to die from cardiovascular reasons, 46 per cent more likely to suffer an MI, 56 per cent more likely to suffer heart failure and 38 per cent more likely to require revascularisation.

Royal Brompton Hospital cardiologist Professor Kim Fox said that the results of the trial had shown that ivabradine reduced

myocardial infarction and the need for coronary revascularisation in this group.

Leading Italian cardiologist Professor Roberto Ferrari said the trial had reinforced the need to measure heart rate in all CAD patients.

BEAUTIFUL study results:

www.beautiful-study.com

Exercise may boost memory

Adults with memory problems may find their symptoms improve with exercise, results published in the Journal of the American Medical Association have shown.

The trial in 138 adults aged over 50 years who reported memory

problems but who did not meet the criteria for dementia involved 150 minutes of moderate intensity exercise each week, equivalent to about 20 minutes a day.

At the end of the 18-month trial the exercise arm showed a

small improvement in cognition compared with the non-exercise arm.

The investigators suggested that the result was a significant finding in relation to the small amount of exercise involved.

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*One application is usually sufficient with the verruca or wart disappearing or falling off over the next 10-14 days. Persistent verrucas or warts may require two or three applications.

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Adverse events should be reported.
Reporting forms and information can be found
at www.yellowcard.gov.uk. Adverse events should also be
reported to Roche Products Limited.
Please contact Roche Drug Safety Centre on: 01707 367554

Roche **PRESCRIBING INFORMATION. XENICAL (orlistat).** Indications: XENICAL is indicated in conjunction with a mildly hypocaloric diet for the treatment of obese patients with a BMI ≥ 30 kg/m², or BMI ≥ 28 kg/m² with associated risk factors. Treatment should be discontinued after 12 weeks if patients have been unable to lose $\geq 5\%$ of their body weight. **Dosage and administration:** One capsule immediately before, during or up to one hour after meals (only 30% of calorie intake from fat). **Contra-indications:** Chronic malabsorption syndrome, cholestasis, breast-feeding, known hypersensitivity to any component of the product. **Precautions:** Monitor anti-diabetic drug treatment. Co-administration of orlistat with ciclosporin is not recommended. Treatment may potentially impair the absorption of fat-soluble vitamins (A, D, E, and K), patients should be advised to have a diet rich in fruit and vegetables. The possibility of experiencing gastrointestinal events may increase

when orlistat is taken with a diet high in fat. Caution should be exercised when prescribing to pregnant women. Studies have shown no interaction between orlistat and oral contraceptives, however an additional contraceptive method is recommended to prevent possible failure of oral contraception that could occur in case of severe diarrhoea. Rare cases of rectal bleeding, generally of mild intensity have been reported and prescribers should investigate further if symptoms are severe or persistent. **Drug Interactions:** A decrease in ciclosporin levels has been observed in an interaction study. Co-administration with acarbose should be avoided. INR values should be monitored if patient is on warfarin or other anticoagulants. Reinforcement of clinical and ECG monitoring is warranted if patient is on amiodarone. **Side-effects:** Please consult the Summary of Product Characteristics for full details of adverse events. **Common:** Influenza, anxiety, headache, respiratory infection, urinary tract infection, menstrual irregularity, fatigue and gastrointestinal such as oily spotting, abdominal pain, increased defecation and flatulence. Treatment adverse events in type 2 diabetics included hypoglycaemia and abdominal distension. The incidence of adverse events decreased with prolonged use of orlistat. **Serious:** Very rare cases of increases in liver transaminases and alkaline phosphatase and also cases of hepatitis. Very rare cases of bullous eruptions, diverticulitis and cholelithiasis. Rare hypersensitivity reactions of angioedema, bronchospasm and anaphylaxis. **Legal Category:** POM. **Presentation and Basic NHS Cost:** Xenical 120mg

(84 capsules) £33.58. **Marketing Authorisation Number:** EU/1/98/071/003 (84 capsule blister pack). **Marketing Authorisation Holder:** Roche Registration Limited, 6 Falcon Way, Shire Park, Welwyn Garden City, AL7 1TW, UK. Further information is available on request. Xenical is a registered trade mark. **Date of preparation:** June 2007. **References:** 1. Hollander PA et al. Diabetes Care 1998; 21: 1288-1294. 2. Hanefeld M and Sachse G. Diabetes Obes Metab 2002; 4: 415-423. 3. Sharma AM and Golay A. J Hypertens 2002; 20: 1873-1878. 4. Broom I et al. Br J Cardiol 2002; 9: 460-468. 5. Torgerson JS et al. Diabetes Care 2004; 27: 155-161.

XENICAL
orlistat 120mg

Block fat and help change their future

GI support from herbal sources

Floradix IntestCare is a new herbal supplement said to help maintain intestinal and digestive health, available from Salus. With a fruity taste, the product contains turmeric to maintain a healthy gut, apple-plum extracts to stimulate digestion and magnesium to bind water in the stool.

It is suitable for vegetarians and vegans and is recommended for people who want to actively support their digestion alongside a healthy diet and lifestyle, says Salus. Dosage for adults is 20ml daily. It is not recommended for children.

Press advertising is appearing in consumer titles including Top Santé, Weight Watchers, Yours and People's Friend. An introductory discount of 20 per cent is running throughout September and October. Counter displays are



available containing 40x10ml free taster samples alongside information leaflets.

Price and Pip code:
£10.95/250ml; 339-9938
Salus
Tel: 01925 825679

Oral-B brings more power to the bristles

Oral-B is hoping to start a 'brushing revolution' with its new promotional campaign. Spanning television, print and online advertising and PR, the multi-million pound campaign aims to encourage consumers to use a rechargeable brush with the tagline 'For that dentist clean feeling'.

The brand says it is repositioning all its in-store range of powered brushes using merchandising units with strong imagery and clear product descriptions. The range has a starting price of £29.99 for Oral-B Vitality brushes rising to £139.99 for the Triumph with SmartGuide that gives feedback to the user on how well they are brushing.

Oral-B recommends stocking the complete range and making use of the available merchandising and POS materials.



Product info:
Procter & Gamble
Tel: 0800 7311 792



Legal Status P. Further information from
Thornhill & Ross Ltd, Huddersfield, HD7 5QH



Abbott ensures energy boost

Ensure TwoCal is a new high-energy nutritional drink for patients with increased nutritional requirements, such as those with poor wound healing, post operative patients, cancer patients and people with cystic fibrosis.

The new product provides 2kcal/ml, with each 200ml pack providing 17g protein, high levels of vitamins and minerals, and fructo-oligosaccharides, said to support good digestive health.

The product can be also be used in cooking, for example in soup,

rice pudding, porridge or sauces. Recipes will be put on Abbott's website in the 'Recipe bank' section in the patient information area and will be available via the Nutritional Services Helpline (below) by the end of September.

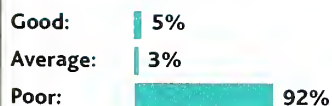
Four flavours are available.

Pip codes: vanilla 338-8956; neutral 338-8931; strawberry 338-8949; banana 338-8923
Abbott Nutrition
Tel: 0800 252882
www.abbottnutritionuk.com

Retail TALK

How would you rate your
suncare sales this year?

WEB VERDICT:



Off the shelf view: It's official, our online voters have declared we've had a miserable summer, certainly as far as suncare sales are concerned. For the 5 per cent of you reporting good sales, I can only assume you're in the UK's sunniest spot for last month, Lerwick in Shetland, or else you're at an airport, making the most of the stampede to sunnier climes!

This week: How useful are planograms? Vote online at www.chemistanddruggist.co.uk/prodnews

Friends get fruity

A sugar-free blackcurrant flavoured variant has been added to the Fisherman's Friend medicated confectionery range. The product is expected to appeal to a younger audience and to encourage trial.

Supporting the launch, over a million packs are being given away in experiential marketing activities between now and next March with the focus on students at 12 universities, mainly in the north of England. Activity is fronted by two former Gladiators, Jet and Hunter. Meanwhile, the brand is continuing its sponsorship of the World's Strongest Man competition, which is on channel five over Christmas.

Price and Pip code:
69p/25g, 339-1935
Jenks
Tel: 01844 293619
lisa.mullins@jenks.co.uk

HEDRIN 97% EFFECTIVE*. NO OTHER HEAD LICE TREATMENT TOPS THAT

*Data on file

Hedrin 4% Lotion (Dimeticone, Legal Status P) for the treatment of head lice. Further information from Thornton & Ross Ltd, Huddersfield, HD7 5JX

Bassetts relaunch makes it clear

The Bassetts Soft & Chewy vitamins range has been relaunched to help consumers choose the right VMS product. The pack designs are intended to be easy to follow, says manufacturer Ernest Jackson.

New product formulations have been introduced to suit consumer needs and age groups. Product launches include Active Health multivitamins, Early Health ABCDE in orange and strawberry flavours



and orange flavoured vitamin C and zinc pastilles.

The new-look range is being supported with a £1.4 million campaign targeting ABC1 mums with children aged 3-18 years. Television advertising is scheduled from October 6 until November 21 on GMTV, five and satellite using the 'Taking vitamins doesn't have

to be hard' strapline.

Magazine advertising is running from this month until November in titles including Hello! and Marie-

Claire. Online, a new website goes live on October 6.

Prices and Pip codes:
see C+D monthly Price List
Ernest Jackson
Tel: 01363 636100
www.bassettsvitamins.co.uk

Products in brief

Neon nails

The Miss Sporty make-up brand is extending its offering with the launch of Clubbing Colours. The nail varnish is available in five neon shades: taxi yellow, paparazzi pink, salsa red, manga orange and summer sea blue.

Price: £1.99/7ml

Coty, tel: 01233 656366

In for the long-haul

An upgraded Lasting Finish 16Hr Mineral-enriched foundation will be launched this month by Rimmel. Promising a fresh and fade resistant finish for 16 hours, the product contains seven minerals to help skin look and feel healthy, says Rimmel. Five shades are available.

Price: £5.99/30ml

Coty, tel: 01233 656366



Products advertised on TV next week

Breathe Right: All areas

ClearZal: All areas except GMTV

First Response Early Results Pregnancy Test: All areas

Frontline Spot On: GMTV, five, Sat, West Country

Nytol: All areas

Sensodyne: All areas

PharmaSite for next week: Nytol – windows, Nytol – in-store, Nytol – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

balance activ

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Medical Experts*

Vaginal Gel

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neutralise abnormal vaginal odour
rapidly relieve vaginal discomfort
and abnormal discharge
treat and prevent Bacterial Vaginosis
by restoring normal pH & vaginal flora

7
Single Use
Dose

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✓ Abnormal discharge
✓ Discomfort

balance Activ Vaginal Gel restores the natural pH balance in the Vagina.

www.balanceactiv.com

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MUR or less?

With news that some pharmacists are being pressurised to perform more medicines use reviews, the **RPSGB's Professional Services Directorate** examines the use of targets in delivering the service

Pharmacists will recognise that MURs – part of the pharmacy contract in England and Wales – are an important type of concordance review, which delivers great value to patients.

MURs can help to solve significant problems the patient may be facing and are also an important professional service that takes pharmacists a step further to developing a more clinical service. It is important that as a profession we embrace the increased clinical role that will not only benefit patients but also integrate us further into the multidisciplinary primary care team.

Despite a slow start and some concerns having been expressed about the quality of some initial MURs, there are now encouraging signs that pharmacists are actively engaged in providing this important service. Pharmacists should be looking at the content of the services they deliver to patients, and seeking to adopt best practice.

Counterbalancing this, the Society recognises there has recently been much debate about MURs and the pressure that some pharmacists face from employers to reach targets. While there are important and legitimate drivers to increase the number of MURs, there are also reports some pharmacists feel the approach taken by their employers to reach specific volume targets amounts

to 'harassing techniques' and 'corporate bullying'.

Pharmacists must not be pressurised to achieve targets, especially if they feel the achievement of the targets would compromise patient care.

The role of targets

Targets and incentives for providing a professional service are used throughout

healthcare in hospitals and primary care. For example, the GP contract has a large number of incentives built in as QOF points. There are also a number of prescribing targets such as the proportion of generic prescribing, whereby GPs are given comparative feedback on their prescribing by pharmaceutical advisers with PACT data to compare their prescribing habits, and this helps GPs to compare their practice with their peers.

Targets and incentives are helpful in that they can demonstrate clearly to staff the priorities of a company and encourage them to undertake new roles. In some areas, targets have been found to drive up standards. We also know that some pharmacists view targets and incentives as a significant motivating factor in their role.

While targets can be set, it is however important they do not replace an individual's professional judgement and autonomy in deciding when, for example, an MUR might be appropriate.¹ It is up to the individual pharmacist to decide which patients receive this service, although local PCOs or GPs

may recommend specific groups of patients that may be appropriate for targeting.

The provision of MURs does form part of the community pharmacy contract and therefore there is an obligation on NHS pharmacy contractors to provide this service to patients. As a pharmacist you should not refuse to undertake MURs unless there are valid reasons such as workload pressures or a negative impact on patient safety.

If, however, a pharmacist has been set targets they believe are unachievable they should in the first instance raise their concerns with their line manager. If you don't report your concerns, it is

difficult for the person in a position of authority to respond to them. There should be a two-way communication between the pharmacist and employer to discuss any concerns that either may have. Reconfiguration or prioritisation of work flow, alternative or additional staffing or other ways of working could be considered as part of this.

Target-setting

When setting targets, employers must take care to ensure these do not have unintended consequences:

- MURs should not be conducted on patients who do not need them, simply to reach targets. The Society believes that the value of the MUR to the patient must be maintained.
- If a pharmacist is undertaking an MUR, it may impact on their ability to provide other professional services, which may have a negative effect on patients and staff.

Thus, if targets are to be set, it is important that they take account of the complexities of the situation, and also take account of the wider services and workload of the pharmacy.

Targets should be agreed with the pharmacist concerned to ensure they are achievable and will not compromise patient care in other areas. As with any new service, it may also be difficult to judge the impact on other services until experience has been gained; targets may therefore need to be adjusted in light of experience.

Supporting pharmacists

The Society recognises and welcomes the time and finance that has been invested by pharmacy owners in supporting pharmacists to undertake MURs and other new services.

Employers have a duty to ensure that staff who raise genuine concerns are appropriately supported and protected

Pharmacists may require support in terms of how to conduct an MUR effectively and efficiently, how to find time to conduct MURs, in targeting patients who would benefit from an MUR, and in effective delegation of certain tasks to other staff. The Society's English and Welsh pharmacy boards will be working with other professional organisations to address a number of these issues.

The care of patients is a pharmacist's first concern² and patient safety must not be compromised in an attempt to reach MUR targets. Employers and pharmacists have to recognise that undertaking MURs is likely to result in an increased workload, and therefore the staffing structure of the pharmacy may need to change to take account of this.³

As the role of the pharmacist evolves to having a more clinical focus, it is important to remember that times of change can be stressful for individuals. Employers should be alert to signs of stress, and support pharmacists through the period of change.

Responsibility for safety

Pharmacists have a duty of care to their patients. This is recognised in law and in the Code of Ethics.

Pharmacists must be able to raise concerns about patient safety, and should be empowered to take action where they have concerns about the safety of a pharmacy. Employers have a duty to ensure that staff who raise genuine concerns are appropriately supported and protected.

References

1. Principle 2.2 of the Code of Ethics for Pharmacists and Pharmacy Technicians
2. Principle 1 of the Code of Ethics for Pharmacists and Pharmacy Technicians
3. Standard 2.3 of the professional standards and guidance for pharmacists and pharmacy technicians in positions of authority.

Support from the Society

The Society is currently developing an MUR multidisciplinary audit tool that will demonstrate the benefit and quality of MURs. The audit aims to help pharmacists measure the quality of the MURs undertaken; it is planned for this to be available from spring 2009. The audit toolkit will help to demonstrate the benefit of MURs and in so doing help commissioners to understand them.

If you have concerns about any breaches of the requirements of the Code of Ethics, you can contact the legal and ethical advisory service (email: leadvice@rpsgb.org or tel: 0207 572 2308), or you can make a formal complaint to the Society's fitness to practise and legal affairs directorate.

The Listening Friends Scheme also offers a free listening service to pharmacists suffering from stress. The scheme is supported financially by the Benevolent Fund and, although it was set up by the Society, it operates wholly independently. Help can be obtained anonymously. To access the scheme, any pharmacist should initially telephone the automatic answering service on 0207 572 2242.

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- Working within and across Group businesses on strategies to enhance and develop PHOENIX's UK market position.

The Candidate

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- it also desirable for the candidate to have commercial experience and within the pharmaceutical industry.

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C+D is part of CMP Medica, the global healthcare division of United Business Media. As part of one of the largest publishing companies in the UK, C+D offers a great working environment and all the benefits you would expect from a major employer.

If you think you have what it takes, email your CV and a covering letter to Gary Paragpuri MRPharmS, Editor, at gparagpuri@cmpmedica.com or post it to Chemist+Druggist, CMP Medica, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE. Closing date: September 29, 2008



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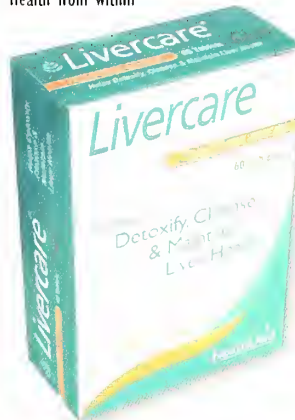
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Midnight money maker



Hull pharmacist Cath Bourne (left) and senior assistant Yvette Turner have raised over £400 for charity in a 12-mile sponsored midnight walk across the Humber. The money generated will go to local palliative care charity Dove House Hospice, which was chosen, said Cath, because "the hospice movement has touched most people at some time. They provide peace and hope while allowing those precious days to be lived to the full".

The walk was fun, Cath said, but added: "Under the Humber Bridge at one in the morning is a spooky place to be".

You can help boost Cath and Yvette's fundraising total at www.justgiving.com/cathbourne

Rx factor mark two



Dementia, brain injury, mental health and patients with other conditions could in the future be prescribed singing, according to one university.

A Canterbury Christ Church University press release said findings on music therapy from

"world-renowned health experts... could one day pave the way for singing on prescription".

The idea brings a whole new meaning to the phrase 'Rx Factor', coined by the Society in its bid to find four media faces of pharmacy.

Reports that the NPA was planning to launch a training package for pharmacists to qualify in singing instruction, in order to fulfil the scripts, were unconfirmed as C+D went to press.

Get knotted

A Dragons' Den reject has been plucked from his descent back into relative obscurity by a deal with Boots.

Since being rejected by the Den's millionaires last year, hairdresser Shaun P has achieved an £800,000 turnover with his "revolutionary hairbrush", the Tangle Teezer. And from this week the Tangle Teezer will be available in 600 Boots stores across the UK.



Sigma supports Uganda medical mission

A team of 37 health professionals from the UK, USA and Canada were able to provide Ugandan patients with 40kg of essential medicines, thanks to Sigma Pharmaceuticals.

The generics manufacturer responded to a plea from the team, which has set up a medical camp expected to treat over 5,000 patients in a two-week humanitarian mission.

Sigma MD Bharat Shah said: "We are very proud to support the health professionals in their mission."

10-second interview



Sandra Melville is chair of the RPSGB Scottish Pharmacy Board

First job? Selling make-up for a company like Avon. I was very young at the time.

School nickname? I don't think you could print that.

What do you drive? A Peugeot. I'm not that bothered about cars.

What is your guilty pleasure? Chocolate.

Who is your dream date? Jon Bon Jovi.

Football or rugby? Football.

Gordon Brown or David Cameron? Frying pan or fire? Probably David Cameron.

Favourite holiday destination? Easdale Island, where I live on the west coast of Scotland.

Web comment of the week

Technicians to miss out on full membership of professional body
Posted by Kay Crockatt, on 29/08/2008 08:53

I think it's a mistake to separate technicians from the main professional body. In practice our jobs would be severely hampered without them... we should be encouraging their professionalism in their area



Have your say on C+D's website
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August 2008

To give your patients the maximum benefit of your expertise, you need to review and continually update your knowledge. The Pharmacy Update modular course has been devised to provide you with an effective and enjoyable way to do this.

You can test your increased understanding of topics covered in August's Pharmacy Update by answering the questions below. Those pharmacists and pharmacy technicians who wish to register their answers may phone our telephone marking service on 08705 800281 (see overleaf for details). Pharmacists and technicians who register will automatically be provided with a module completion certificate, which may be presented to primary care organisations and other bodies as independent verification of the amount of CPP-accredited continuing education you have undertaken, as part of your continuing professional development.

The questions below relate to modules carried in August's Pharmacy Update.

● Headache (module 1447) – August 23

● Tuberculosis (module 1448) – August 30

Correctly answering 80 per cent of all questions is sufficient to achieve two hours' continuing education credit. Alternatively, each module can be answered individually, with an 80 per cent pass rate leading to the indicated units of continuing education credit.

Only tick the boxes which are correct statements or answers.

Module 1447

Headache

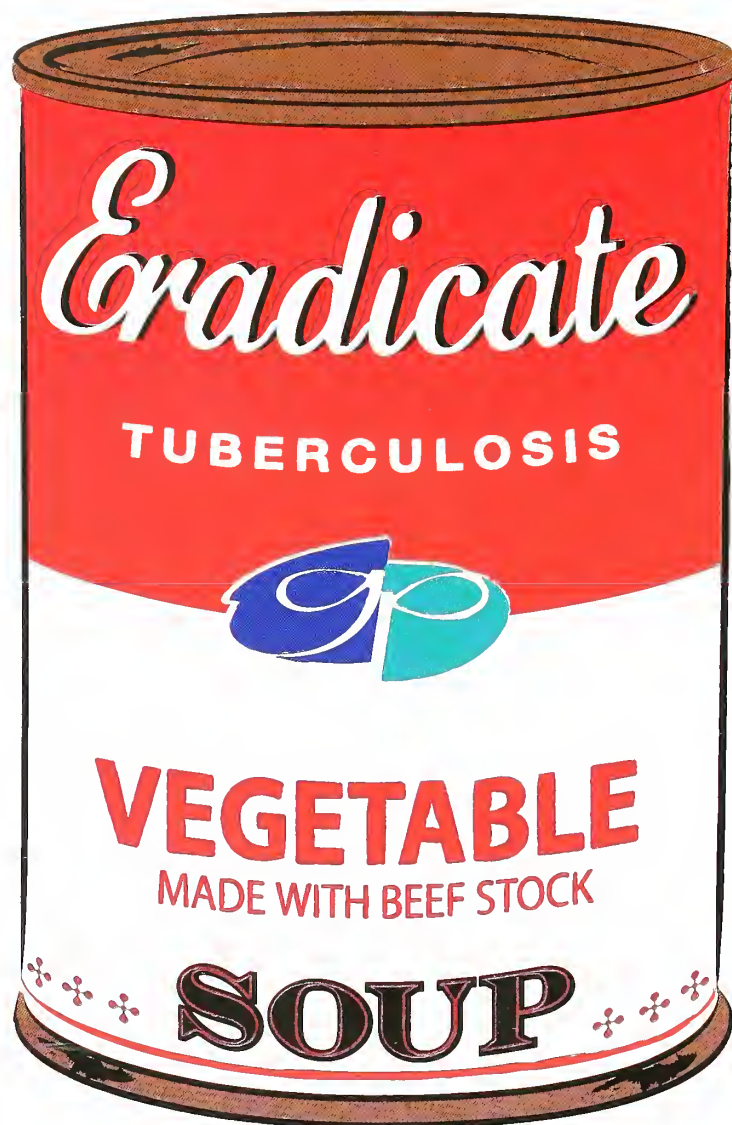
1. Aspirin should not be taken in pregnancy but can be taken by women who are breastfeeding True ☐1 False ☐0
2. Aspirin and ibuprofen should be avoided in patients who are also taking methotrexate True ☐1 False ☐0
3. Ibuprofen can be recommended for treating headaches in patients who are taking lithium True ☐1 False ☐0
4. Antihistamines are included in some analgesic preparations as they may have a muscle relaxant action True ☐1 False ☐0
5. A patient with trigeminal neuralgia may present with a searing pain around the side of the head or around the cheek and upper or lower jaw True ☐1 False ☐0
6. An adult over 18 may purchase prochlorperazine maleate buccal tablets OTC for vomiting associated with migraine provided a doctor has previously diagnosed the condition True ☐1 False ☐0
7. Typically cluster headaches occur:
 - a) At the same time each day and last between 10 minutes and several hours ☐
 - b) At different times of the day and last between 10 minutes and several hours ☐
 - c) As a tight band of pain around the head several times a day ☐
 - d) Mostly in women around the time of menstruation ☐

Module 1448

Tuberculosis

1. Both pulmonary and extra pulmonary tuberculosis are contagious True ☐1 False ☐0
2. All babies born in the UK are given a BCG vaccination at birth True ☐1 False ☐0
3. Rifampicin accelerates the metabolism of oestrogens so may reduce the effectiveness of hormonal contraception True ☐1 False ☐0
4. Pyrazinamide is an unlicensed treatment for tuberculosis suitable for patients with impaired renal function True ☐1 False ☐0
5. Multi-drug resistant tuberculosis is resistant to rifampicin and isoniazid True ☐1 False ☐0
6. Prescriptions for tuberculosis medicines presented at the pharmacy are now free from prescription charges True ☐1 False ☐0
7. Which one of the following statements is true: The standard treatment for tuberculosis is...
 - a) Rifampicin, isoniazid, pyrazinamide and ethambutol for six months ☐
 - b) Rifampicin, isoniazid, pyrazinamide and ethambutol for two months, then rifampicin and isoniazid for four months ☐
 - c) Pyrazinamide and ethambutol for two months, then rifampicin and isoniazid for four months ☐
 - d) Rifampicin and/or isoniazid for six months ☐

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To use the telephone marking service you will need access to a touch tone telephone. The service is interactive – listen to the instructions and press buttons 1 to 4 to indicate your answer. Please note calls are charged at standard national rates, NOT premium rates.

Module completion letters will be sent to registered pharmacists and technicians twice a year, indicating which Update Modules have been undertaken in each half year. Letters will be dispatched in August 2008 and February 2009. The number of hours of accredited continuing education per month will vary, but over the year will be a minimum of 30 hours.

Accredited Pharmacy Update Modules and MCQs are available on the C+D website, www.chemistanddruggist.co.uk/update

These two distance learning Modules, consisting of two articles and this question paper, have been registered with the College of Pharmacy Practice as each providing one unit of postgraduate education towards the College's continuing education requirement. C+D Pharmacy Update Modules are, where indicated, accredited by the College of Pharmacy Practice.

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